



Reservoir High School Music

2013-2014

RESERVOIR HIGH SCHOOL MUSIC DEPARTMENT EMERGENCY PROCEDURE/HEALTH INFORMATION

STUDENT INFORMATION	
Name: _____ Birth Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> M <input type="checkbox"/> F <input type="checkbox"/>	
Address: _____ Home Phone: (<input type="text"/>) - <input type="text"/>	
City: _____, MD Zip: _____ Cell Phone: (<input type="text"/>) - <input type="text"/>	
e-Mail: _____ Expected Year of Graduation: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
MOTHER/GUARDIAN Use info above: <input type="checkbox"/>	FATHER/GUARDIAN Use info above: <input type="checkbox"/>
Name: _____	Name: _____
Address: _____	Address: _____
City: _____, MD Zip: _____	City: _____, MD Zip: _____
Home Phone: (<input type="text"/>) - <input type="text"/>	Home Phone: (<input type="text"/>) - <input type="text"/>
Cell Phone: (<input type="text"/>) - <input type="text"/>	Cell Phone: (<input type="text"/>) - <input type="text"/>
e-Mail: _____	e-Mail: _____
IN EVENT OF MEDICAL URGENCY, PARENTS WILL BE NOTIFIED FIRST. EMERGENCIES WILL BE TAKEN TO THE CLOSEST HOSPITAL. PARENTS WILL BE CONTACTED AS SOON AS POSSIBLE. PLEASE PROVIDE AN ADDITIONAL CONTACT	
Relative/Other Party: _____ Contact Phone: (<input type="text"/>) - <input type="text"/>	
HEALTH INFORMATION (You may discuss the contents of this form with the Trip Nurse.)	
HEALTH CONDITIONS/RECENT OPERATIONS, if any	HANDICAPPING CONDITIONS/LIMITATIONS, if any
ALLERGIES? Y / N (If yes, please describe symptoms/reaction)	MEDICATIONS (Prescription OR OTC)? Y / N If prescription or over-the-counter medications are to be taken, a WRITTEN ORDER from your physician is required on the MEDICATION FORM. This is a separate form.
DIETARY RESTRICTIONS? Y / N (please describe)	OTHER COMMENTS / INFORMATION
PHYSICIAN CONTACT INFO	
Name: _____ Office Phone: (<input type="text"/>) - <input type="text"/>	
PERMISSION IS GRANTED FOR TREATMENT OF THE ABOVE-NAMED STUDENT BY A PHYSICIAN AND/OR HOSPITAL FOR ANY MEDICAL EMERGENCY. EVERY EFFORT WILL BE MADE TO CONTACT THE PARENT/GUARDIAN AS SOON AS POSSIBLE.	
Signature: _____	Origin Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Signature: _____	Review Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Signature: _____	Review Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
Signature: _____	Review Date: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>
THE INFORMATION PROVIDED WILL BE HELD IN CONFIDENCE BUT MAY BE SHARED WITH STAFF TO MAINTAIN STUDENT SAFETY	
AFFIX COPY OF INSURANCE CARD - FRONT	AFFIX COPY OF INSURANCE CARD - BACK